Healthpoint

Information from the Division of Health Care Finance and Policy

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DENTISTRY NEEDS MORE ATTENTION BUT SHOULD NOT FOLLOW MEDICINE

Massachusetts is an internationally recognized leader in medical care, but dental care does not share the limelight. Although largely preventable, dental decay is the most common chronic condition of childhood, affecting 84% of all children nationally by age 17.[1] While newspapers throughout the Commonwealth are filled with articles about health care, these stories are about medicine, not dentistry. Even the appropriation of the term "health insurance" to mean medical, but not dental, insurance is telling evidence that dental care generally takes a backseat to medical care.

Although they share many characteristics, dentistry and medicine have diverged in significant ways, particularly over the last twenty years. While medicine appears to have trumped dentistry in visibility and importance, it is a profession in turmoil. Physicians are unhappy with their lost autonomy, interrupted relationships with long time patients, and severe pressure over productivity. Generally, dentists have not experienced these types of professional losses; their challenge is to work for the recognition of oral health as a vital part of overall health status while avoiding some of the unfortunate circumstances now faced by physicians. This issue of *Healthpoint* examines the structure of the dental care system particularly in contrast to our medical system and describes some ramifications of oral health's second class status.

Delivery Structure

The dental industry today looks remarkably like the medical industry of the early 1980s. Steep increases in medical insurance premiums facilitated the swift incursion of managed care into medicine, propelling physicians into larger and larger groups for perceived economies of scale, to amass capital for computer systems, and to bulk up for negotiating with HMOs. In addition, and quite significantly, many hospitals purchased medical practices to ensure the flow of patient referrals, causing many physicians to transition from self-employment to employee status for the first time. This has not occurred in dentistry. Almost all dentists are still in private practice, mainly solo, paid either by private fee-for-service (indemnity) dental insurance or out-of-pocket by their patients.

Dentistry is efficient in that it relies heavily on cost-effective general practitioners who, in turn, rely heavily for preventive care on very cost-effective dental hygienists. While dental hygienists and dental assistants are less broadly and deeply trained (par-

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ticularly in treatment) than nurses and physician assistants, they have been more successful in carving an independent role for themselves and are a moderating influence on the cost of dental care.

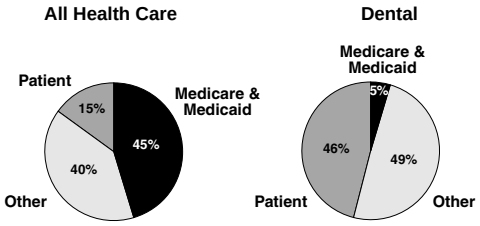
Coverage

As early as 1957, the American Dental Association endorsed prepaid dental care while for years the American Medical Association adamantly opposed prepaid medical insurance, regarding it as socialized medicine. Yet in 2000, more than a third (35.4%) of Massachusetts adults ages 18 and older reported that they lacked dental insurance[2] compared with only 7% who reported that they lacked medical insurance.[3] In that same year, Massachusetts ranked among the top ten states for enrollment in prepaid dental plans,[4] even though just 51% of Massachusetts workplaces reported offering dental insurance when surveyed in 2001.[5] Nationally, premiums for individual dental coverage averaged $12-$25 monthly in 2000,[6] while the 2001 average monthly medical insurance premium in Massachusetts was $295 for individual coverage.[7] Despite the significantly higher cost, 69% of Massachusetts establishments offer medical insurance.[8]

Out-of-Pocket Spending

The percent of Massachusetts adults reporting a dental visit (77%) is higher than the 65% reporting dental insurance (and similar to the 80% reporting a routine medical checkup), so it appears that at least some people are willing and able to pay out-of-pocket for dental visits.[9] The Centers for Medicare and Medicaid Services (formerly HCFA) estimated that nationally, patients paid out-of-pocket for 46% of dental expenditures, but for only 15% of total health care expenditures (including dental) in 1999.[10] In contrast to medicine, the relative scarcity of dental insurance and the absence of managed care in existing dental plans means that those people who seek care have always had to assume at least some responsibility for their dental bills. This has contributed to dentistry's relatively stable prices and, many would argue, has promoted the responsible use of dental services which employers and policy makers are now trying to re-emphasize in medicine.

Payer Mix: All Health Care versus Dental (1999)



Source: Centers for Medicare and Medicaid Services

One reason many patients pay for dental care out-of-pocket is that they can. Managed care in medicine owes its broad acceptance in large part to skyrocketing premium increases stemming from rapid pharmaceutical and technological advances. Dental prices have been relatively flat and more affordable because dentistry has not been similarly transformed. In addition, dentistry is characterized by relatively infrequent need for acute care service, so a routine check-up is often the only item for which one needs to budget.

Public Assistance Programs

Reflective of dentistry's fragmented coverage by public programs, in 1999 Medicare and Medicaid covered only 5% of dental expenditures nationally, but 45% of all health care expenditures.[11] The federal government sends an unfortunate message to the general public about the importance of oral health by deeming the coverage of adult dental services "optional" for state Medicaid programs while requiring coverage for children. In Massachusetts, MassHealth had long included adults in their dental coverage but recently succumbed to extreme budgetary pressure and joined 35 other

states in reducing that coverage for most adults, except for special circumstances. The reduction of most adult dental services within MassHealth is bound to increase existing economic disparities in oral disease and survival rates for oral cancer, and underscores the second class role of dentistry within the world of health care.

Over the past two years, the Commonwealth provided approximately $6 million to community health centers (CHCs) and other community organizations to increase their capacity to deliver dental services to MassHealth members and other low income individuals. This year Massachusetts designated approximately $2 million more to meet even greater anticipated demand. The Uncompensated Care Pool (the state's health care safety net for the uninsured), pays for both preventive and acute dental services at CHCs. In addition, low-cost dental care is available at the Commonwealth's three schools of dental medicine and six schools that train dental hygienists.

Seniors in traditional fee-for-service Medicare are not covered for dental services, but those enrolled in Massachusetts Medicare HMOs have limited dental coverage. The lack of dental coverage by Medicare means that dental care for seniors is problematic. Among Massachusetts seniors in 2000, 60% of those ages 65-74 and 72% of those 75 or older had no dental coverage.[12] A 1999 report stated that 22% of elderly residents had no teeth at all.[13]

Nationally, children lose about 632,000 school days due to oral health problems.[14] Among Massachusetts children ages 3-17, nine percent needed dental care in 2000 but could not get it because of the cost.[15] According to community surveys, dental sealants, among the most cost effective of preventive dental services, have been applied to fewer than 25% of Massachusetts schoolchildren despite strong endorsement by the dental community and federal government. School mouth rinse programs in non-fluoridated communities are rare in Massachusetts even though fluoride mouth rinse has been shown to reduce tooth decay up to 35%.[16]

Which Delivery Structure Supports Uncompensated Care?

Policy makers disagree on the structural factors that facilitate offering free care. One theory is that two by-products of managed care (the emergence of larger provider groups pooling overhead, and large enough patient bases to allow revenues from well insured patients to offset the cost) would encourage more providers to offer free care. Others theorize the opposite: that a recent national decline in the amount of free care physicians provide was due to a decrease in solo or small group practices, a decrease in physicians owning their own practices, and an increase in managed care.[17] The former theory would seem to argue that solo practice dentists would find it difficult to offer free care while the latter theory seems to suggest that dentistry's practice structure would facilitate offering free care. But one significant difference between the two professions confounds the situation: the far greater proportion of self pay patients in dentistry, always acutely price sensitive, discourages the cost shifting essential to financing free care.

What Can Massachusetts Do?

In 1998, for only the third time in fifty years, the Massachusetts legislature called for an assessment of oral health status that called attention to a "collapsing" dental delivery system, particularly for low income residents, and urged the state "to play a leadership role in population-based dental disease prevention and surveillance." It pointed out that although Massachusetts has been in the forefront of public health since the 19th century, 43% of our population live in communities with non-fluoridated water supplies, making the Commonwealth 35th in the nation for this basic public health

measure.[18] A 1998 article by the Massachusetts Dental Society stated unequivocally that "…fluoridation [having been shown to reduce tooth decay by up to 40%] is still the most cost-effective preventive measure for dental disease and needs to be promoted once again in Massachusetts."[19]

Massachusetts also needs to better integrate oral health care into overall health care delivery and the public health infrastructure so it is readily available to everyone. The safety net for low-income adults and seniors must be strengthened and secured particularly because there is likely to be greater demand on it. An important step taking place this spring is fee enhancement by MassHealth for pediatric dental services that should encourage providers to join the program.

Other improvements to our oral health system would include legislative expansion of the number of communities with fluoridated water supplies, increased funding for programs administered by DPH's Office of Oral Health and School Health Unit, and promoting the use of mouth guards by all during contact sports. Finally, more complete integration of dental care data into our public health and medical care databases is crucial to measure our progress moving forward.

Endnotes

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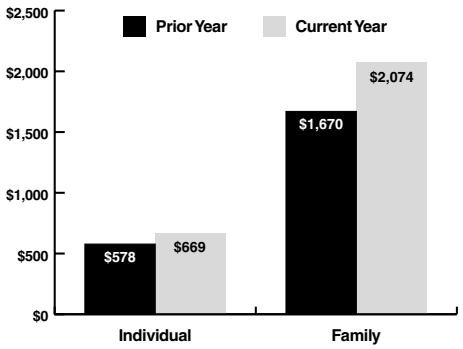
Did you know?

Employers Decreased Contributions to Family Plans

In a recent survey of 1,100 Massachusetts employers, the Division of Health Care Finance and Policy found that from 2000 to 2001, health insurance premiums for an employer's most popular (or only) health plan rose an average of 19% for individual coverage and 15% for family coverage. But while employers kept their contribution to individual health insurance plans steady at 81% of the cost, they decreased their contribution to family coverage from 75% to 73%, on average. The overall premium increase, coupled with the 2% employer rollback in subsidy to family coverage, resulted in an average net increase of 24% (from $1,670 to $2,074 annually) to what employees contribute to their family plans. At the same time, employees with individual plans saw their average contribution to the premium rise 16% (from $578 to $669 annually).

Average Annual Employee Contribution to their Medical Insurance Premium (2001)



Source: Division of Health Care Finance and Policy

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